

LF 2006-0268  
CF



STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
CERTIFICATE OF DEATH

0045306

STATE FILE NUMBER  
2651851

1. DECEDENT'S NAME (First, Middle, Last) (b)(3):CPSA Section 25(c)		2. DATE OF BIRTH (Month, Day, Year)		3. SEX Female		4. DATE OF DEATH (Month, Day, Year) May 26, 2006	
5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS (include AKA's if any)				6a. AGE - Last Birthday (Years)		6b. UNDER 1 YEAR MONTHS 5 DAYS 10	
7a. LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) HOSPITAL OR OTHER INSTITUTION - Name (if not in cities, give street and number and zip code) (b)(3):CPSA Section				7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH Rochester Hills		7c. COUNTY OF DEATH OAKLAND	
8a. CURRENT RESIDENCE - STATE		8b. COUNTY		8c. LOCALITY (check the box that describes the location) <input checked="" type="checkbox"/> CITY OR VILLAGE <input type="checkbox"/> TOWNSHIP <input type="checkbox"/> UNINCORPORATED PLACE		8d. STREET AND NUMBER (Include Apt. No. if applicable)	
(b)(3):CPSA Section 25(c)							
9c. ZIP CODE		9. BIRTHPLACE (City and State or Country)		10. SOCIAL SECURITY NUMBER (b)(3):CPSA Section 25(c)		11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death? N/A	
(b)(3):CPSA Section 25(c)							
12. RACE - American Indian, White, Black, etc. (If Asian, give nationality, i.e. Chinese, Filipino, Asian Indian, etc.) (Enter all that apply)		13a. ANCESTRY - Mexican, Cuban, Arab, African, English, French, Dutch, etc. (Enter all that apply) If American Indian race, enter principal tribe		13b. HISPANIC ORIGIN (Yes or No) No		14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES? (Yes or No) No	
(b)(3):CPSA Section 25(c)							
15. USUAL OCCUPATION Give kind of work done during most of working life. Do not use retired.		16. KIND OF BUSINESS OR INDUSTRY		17. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)		18. NAME OF SURVIVING SPOUSE (if wife, give name before first married)	
N/A		N/A		Never Married			
19. FATHER'S NAME (First, Middle, Last) (b)(6)				20. MOTHER'S NAME BEFORE FIRST MARRIED (First, Middle, Last)			
21a. INFORMANT'S NAME (Type/Print) (b)(6)		21b. RELATIONSHIP TO DECEDENT		21c. MAILING ADDRESS (Street and Number or Rural Route Number City or Village, State, Zip Code) (b)(6)			
22. METHOD OF DISPOSITION Burial		23a. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other location) (b)(6)		23b. LOCATION - City or Village, State (b)(6)			
24. SIGNATURE OF MORTUARY SCIENCE LICENSEE (b)(6)		25. LICENSE NUMBER (of Licensee) (b)(6)		26. NAME AND ADDRESS OF FUNERAL FACILITY (b)(6)			
27a. CERTIFIER (Check only one) <input type="checkbox"/> Certifying Physician - To be used only if death occurred due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner - On the basis of examination, medical investigation, in my opinion, death occurred at the time, date (b)(6) Signature and Title		28a. ACTUAL OR PRESUMED TIME OF DEATH Unknown P.M.		28b. PRONOUNCED DEAD ON (Mo, Day, Yr.) May 26, 2006		28c. TIME PRONOUNCED DEAD 3:34 P. M.	
29. MEDICAL EXAMINER CONTACTED? (Yes or No) Yes		30. PLACE OF DEATH (Home, Hospital, Nursing Home, Hospital, Ambulance) (Specify) Dwelling		31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, D.O.A. (Specify)			
27b. DATE SIGNED (Mo, Day, Yr.) May 27, 2006		27c. LICENSE NUMBER 49398		32. MEDICAL EXAMINER'S CASE NUMBER (if applicable) (b)(6)		33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN (Type or Print) (b)(6)							
35a. REGISTRAR'S SIGNATURE <i>Don M. P...</i>				35b. DATE FILED (Month, Day, Year) June 1, 2006			
36. PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. If diabetes was an immediate, underlying or contributing cause of death be sure to record diabetes in either Part I or Part II of the cause of death section, as appropriate. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequitely list conditions, LEASE, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST a. Pending POSITION ASPHYXIA DUE TO (OR AS A CONSEQUENCE OF) b. Amended July 7, 2006 DUE TO (OR AS A CONSEQUENCE OF) c. W75 T71 DUE TO (OR AS A CONSEQUENCE OF) d. W75 Approximate Interval Between Cause and Death MINUTES							
PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I.				37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown			
39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate or Pending (Specify) Accident				40a. WAS AN AUTOPSY PERFORMED? (Yes or No) Yes		40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) Yes	
41a. DATE OF INJURY (Mo, Day, Yr.) May 26, 2006		41b. TIME OF INJURY Unknown B		41c. DESCRIBE HOW INJURY OCCURRED Trapped face-down against the padding in the corner of the			
41d. INJURY AT WORK (Yes or No) NO		41e. PLACE OF INJURY - At home, farm, street, construction site, wooded area, etc. (Specify) Home		41f. IF TRANSPORTATION INJURY - Driver/operator, Passenger, Pedestrian, etc. (Specify) (b)(6)		41g. LOCATION - Street or Rte. No. City, Village or Twp. State	

Madison Mort

NAME OF DECEDENT  
For use by physician or institution